SERVICE, RATE, AND PAYMENT ADDENDUM

TO

2006 PURCHASE OF SERVICE CONTRACT

This addendum is hereby incorporated into the existing contract known as the 2006 Purchase of Service Contract, entered into freely and independently by and between Richland County Health and Human Services (hereinafter "Purchaser") and INSERT PROVIDER NAME (hereinafter "Provider").

CODE, SERVICE DESCRIPTION, RATE

The definition listed below shall be the definition of service for this contract:

Code Service Description Member Rate Unit .

Provider agrees to provide the services and accept the rate, as defined above in accordance with each member's Individual Service Plan (ISP), during the existence of this contract. Purchaser shall authorize any additional services not included in the ISP and/or above service authorization prior to those services being performed. If Provider provides additional services without prior authorization, Purchaser will not be held fiscally responsible for payment of those services.

No Minimum Requirement

It is understood and agreed by all parties that the Purchaser assumes no obligation to purchase from Provider any minimum amount of services as defined in the terms of this contract.

Medical Assistance Covered Services

If the service provided under this contract is a Medical Assistance covered service, the contract rate will be the provider's approved Medical Assistance rate as it stands January 1st of the contract year. Rate increases issued by the Wisconsin Medical Assistance program will be reflected in Purchaser's contracted rates from the date the Purchaser is notified of the increase. The rate in place shall be the contracted rate, and an adjustment retrospective to the effective date of the new rate paid when new rates are available. Payment for Medical Assistance covered services (as specified in s.49(2) Wis. Stats. and HFS 107 Wis. Admin. Code) shall be the lesser of the Medicaid rate in effect at the time service is provided or the Provider's billed charges.

SERVICE STANDARDS

1. The Provider will provide services that meet the following standard as evaluated by the evidence of compliance.

Member Specific Planning

Standard: Provider's services shall be tailored to individual member needs.

Evidence of compliance:

a) Member reports that needs are being satisfactorily met.
b) Member reports that he/she is adequately involved in care plan.

Communication

Standard: Provider shall communicate well with member, care management team, and informal supports.

Evidence of compliance:

a) Provider shall report any change in member's condition, injury, illness, hospitalization, and deterioration. A change in condition that does not require additional service authorization may be reported by phone during normal business hours to a member of the member's care management team or the on-call worker of the Purchasers. If the member is hospitalized, or if the change in condition necessitates additional or different services to be authorized by the Purchaser, the Provider shall call the Purchaser at the following numbers:

> During Normal Business Hours (8:00 a.m. to 5:00 p.m.)
> Richland County Health and Human Services
> 221 West Seminary Street
> Richland Center, WI 53581
> (608) 647-8821
>
> All Other Times
> Richland County Sheriff's Dept.
> (608) 647-2106 or
> (800) 544-2106 toll free or
> (800) 283-9877 TTY (Wisconsin Telecommunications Relay System)

*Note: The after hours number will connect you with the Sheriff's Department dispatcher. The TYY number will connect you with a service that can relay your message to the Sheriff's Department dispatcher and on-call system. Tell the dispatcher, "**I would like to access the CMO emergency on-call system**". The dispatcher will take your name and number and page the on-call worker, who will then call you back **within** 15 minutes. If a call is not returned within 15 minutes, call the after hours number and have the on-call worker paged again.*

b) Provider shall participate in and receive information from member satisfaction surveys.
c) Provider shall share internal and external survey information with the Purchaser.
d) Provider shall participate, as requested, in case review, staffing, and service planning.
e) Provider shall notify the Purchaser of any licensure visits, reviews, and/or citation within three (3) business days.

Safety

Standard: Members are safe and unacceptable risk is avoided.

Evidence of compliance:

a) Provider shall comply with applicable State and Federal rules, regulations, and licensure as evidenced by review of appropriate documentation. Staff shall be appropriately screened and trained and have required background checks completed by the hire date.
b) Provider shall share with Purchaser, member complaints, grievances, and incident reports.
c) Provider shall communicate to Purchaser unsafe condition when observed.
d) Provider shall work with Purchaser to determine consumer-accepted risk.

2. Provider is responsible to modify services as directed by the Purchaser's staff.

3. Provider shall notify the Purchaser immediately in an emergency situation. An emergency situation is when something occurs that threatens the member's health or level of function and that necessitates the Purchaser to immediately authorize a service.

4. Provider shall notify the Purchaser if there is a change in level of care. A level of care change is a change in member's condition that necessitates a change in the member's service plan, such as the addition or deletion of a service, or an increase or decrease in the number of hours of care.

5. Provider shall notify the Purchaser if there is a situation where Provider cannot provide authorized services. (*Some examples may be member refusal to accept service, or member hospitalization, etc.*)

6. Provider shall notify the Purchaser of all complaints or grievances within fifteen (15) business days of the occurrence of the complaint or grievance, and as directed by the Purchaser's CMO complaint and grievance policy.

7. Provider staff shall participate in training on the CMO's complaint and grievance policy and procedure.

CRITICAL INCIDENT REPORTING

Richland County Health and Human Services CMO is required under Federal Law and our contract with the State of Wisconsin to "protect the health and welfare of individuals provided services." Part of this requirement calls for the Purchaser to collect information about critical incident involving our members. Collecting this information and analyzing this information enables the State and Richland County Health and Human Services CMO to protect the health and welfare of our members by:

- Recognizing incidents in which harm has occurred.
- Responding to each incident in a way that, to the extent possible, ameliorates any harm that has occurred and prevents any future harm.
- Analyze all incidents to reduce or eliminate the causes of such harm.

Definitions

1. "Critical Incident" means an event, incident or course of action or inaction that is either "unexpected" or is the result of alleged abuse, neglect, or other crime, or a violation of client rights that resulted in:

   a. Harm to the health, safety, and well being of an enrollee or another person, or
   b. Harm to emotional health due to threats, intimidation, or acts that humiliate a member.

c. Substantial loss in the value of the personal or real property of an enrollees or another person (substantial loss means that the property needs to be repaired or replaced).

2. "Unexpected" means an event or incident that occurs without warning and was not anticipated or considered probably. Examples include calls summoning police or fire department services, and member falls.

   a. Providers must report to the member's team, any police, ambulance, fire, or related emergency personnel contacts related to the member.
   b. Providers are expected to report any unknown or suspected falls of a member. The Purchaser will consider each individual report of a fall to determine whether it meets the local definition of a critical incident fall.

3. "Abuse" means any of the following, if done intentionally, negligently, or recklessly:

   a. An act, omission, or course of conduct by another that is not reasonably necessary for treatment or maintenance of order and discipline and that does at least one of the following:

      1. Results in bodily harm or great bodily harm to a member.
      2. Intimidates, humiliates, threatens, frightens, or otherwise harasses an enrollee.

   b. The forcible administration of medication or treatment with the knowledge that no lawful authority exists for the administration or performance.

4. "Neglect" means an act, omission, or course of conduct by another that, because of the failure to provide adequate food, shelter, clothing, medical care or dental care, creates a significant danger to the physical or mental health of an enrollee.

5. "Crime" means conduct, which is prohibited by State law and punishable by fine or imprisonment or both. Conduct punishable only by forfeiture is not a crime.

6. "Client Rights" means rights in Family Care as outlined in applicant materials and member handbook.

Provider Requirements

1. All individuals or entities providing services to members of Richland County Health and Human Services CMO are required to report critical incidents as defined above to the Purchaser as soon as possible after the discovery of the incident. All death of CMO members must be reported to the Purchaser within twenty-four (24) hours, whether unexpected or not. This can be accomplished by calling the number referenced above.

2. Providers are required to cooperate with the Purchaser's investigation of an alleged critical incident through access to records, staff, and any other relevant sources of information.

   IMPORTANT NOTE: Reporting critical incidents and cooperating with subsequent investigations by Purchaser does not relieve the Purchaser or Provider of other certification, licensing or regulatory requirements for reporting critical incidents, including requirements to report and investigate deaths or abuse and neglect of residents of certain facilities (e.g. s.50.034, s.50.04, HFS 12, 13, 83, and 88)

Whenever an employee of the Provider or any of its subcontract agencies believes that abuse, material abuse, neglect, or self-neglect of an elderly person has occurred, the employee shall make a report to Richland County Health and Humans Services as required under Wisconsin Statute 46.90.

Empowerment

Providers of direct care services are required to adopt practices that are supportive of the goals of self-advocacy for people with disabilities.

CLAIMS

Claims Submission

1. Purchaser shall pay all clean claims received in a timely manner. The Purchaser shall pay 90% of clean claims that receive advance authorization within thirty (30) days of receipt of the claim and 100% of claims within ninety (90) days of receipt. (*Note: payment schedule may vary month to month*).

2. Purchaser shall reject any claim that does not include the elements of a clean claim. Purchaser shall send the rejected claim back to the Provider for correction.

3. If Provider electronically bills or conducts any of the electronic transactions covered by the Health Insurance Portability and Accountability Act (HIPAA) with the Purchaser, then Purchaser and Provider shall conduct all electronic health care administrative transactions covered by HIPAA consistent with the Electronic Transactions and Code Sets Rule.

4. Provider shall submit clean paper claims to the following address:

   Richland County Health and Human Services
   CMO Claims Department
   P.O. Box 288
   Richland Center, WI 53581

5. If the service provided under this contract is a non-Medical Assistance covered service, elements of a clean claim are as follows:

   a. Client name or client number.
   b. Number of units of service provided.
   c. Rate per Unit
   d. Total fee.
   e. Amount paid by third party payer.
   f. Amount of cost share paid by client (*if applicable*)
   g. Net fee.
   h. Dates of services (*one month per invoice*)
   i. Service Code.

6. If the service provided under this contract is a Medical Assistance covered service, the claim must be submitted in a format and coding system acceptable to Wisconsin's Medical Assistance program.

7. For claims previously billed to a third party payer, attach a copy of the Remittance Advice or Explanation of Medicare Benefits to the claim form.

Claims Payment

1. Purchaser agrees to pay Provider for the services provided in accordance with this contract at the rate(s) specified in this Addendum. Payment for Medicaid state plan services (*as specified in s. 49.46(2) Wis. Stats. And HFS 107 Wis. Admin. Code*) for Medicaid recipients who are Covered Clients will occur through the Medicaid program in accordance with the Medicaid policies and procedures.

2. Provider shall submit all clean claims as described in this Addendum. Provider agrees to bill Purchaser by the 10th of each month, but no later than ninety (90) days from the time of services provided, unless the parties mutually agree to a longer period. Purchaser shall pay 90% of claims that receive advanced authorization within thirty (30) days of receipt of a complete and accurate claim and 100% of those claims within ninety (90) days of receipt.

3. Provider agrees to follow Coordination of Benefits (COB) procedures established by the Wisconsin Office of the Commissioner of Insurance, acknowledging that the Purchaser is always the secondary payor in circumstances where an Eligible CMO Member is covered by a third party payor. The Provider will bill other primary third party payors first. In the event that the primary payor denies the claim or makes only a partial payment on the claim, the Provider will submit invoices to the Purchaser within forty-five (45) days of receiving the primary payor's denial or partial payment. Purchaser will then determine the appropriate additional payment, if any.

4. The Provider shall supply Purchaser with a Surety Bond per Wis. Stats. 46.036(3)(f) if Provider is receiving an advance payment in access of $10,000. The Surety Bond must accompany the signed contract that is returned to the Purchaser, if required. The insurer issuing the Surety Bond must be licensed to conduct business in Wisconsin.

5. For services performed under this contract and provided to an Eligible CMO Member and Covered Client, the Provider agrees to accept payment made by the Purchaser and/or any third party payors as payment in full and will not bill, charge, seek remuneration or compensation from or have any recourse against Eligible CMO Members or the Wisconsin Department of Health and Family Services for amounts not fully paid by the Purchaser. This provision continues in effect even if the Purchaser ceases to operate the CMO programs.

6. For residential providers and nursing homes, in the case of a member's hospitalization or other absence from a facility, the Purchaser will pay up to fifteen (15) days bed hold, effective on the first full day the member is away. If a member is discharges from a residential facility at the provider's request, payment will end on the day of discharge. For nursing homes, the Purchaser will pay bed hold charges in accordance with Wisconsin Medical Assistance policy. The purpose of a bed hold payment is to ensure the bed is available for the person when they are returning to the facility, in the event the person is discharged from a facility with no plans to return, a bed hold will not be paid

7. In addition, residential providers and nursing homes also please note that the daily contracted rate is the full daily rate listed in this Service, Rate, and Payment Addendum for each level of care. This is the rate that you have accepted and payment of this amount will constitute payment in full for contracted services. Member liability will be paid directly to

the Purchaser. No payments are to be collected by Providers from Members without the prior knowledge and approval of the Purchaser.

Withholding of Payments

Purchaser may withhold or decrease future payments to Provider for claims paid in error.

Purchaser may withhold any and all payments otherwise due Provider, if Provider fails to perform in accordance with the 2006 Purchase of Service contract and/or any addendums, attachments, amendments, or exhibits attached to thereof and Purchaser may hold the payments until Provider corrects its failure to perform.

Claims Dispute

If Provider wishes to dispute a claim denial or partial claims payment, it may request that the Purchaser reconsider its action by filing a written request with the Purchaser's Provider Network Developer within sixty (60) days of Purchaser's action. Provider may appeal Purchaser's reconsideration decision or failure of Purchaser to respond within forty-five (45) days of a reconsideration request, by filing a written request to the Department of Health and Family Services (DHFS) within sixty (60) days of the Purchaser's final decision or failure to respond. In filing a request for reconsideration or appeal, Provider shall clearly mark it as an "appeal" and indicate the Provider's name, address, date of service, date of billing, date of rejection, and reasons for Provider's request for reconsideration or appeal.

ENTIRE AGREEMENT

This addendum constitutes the entire understanding and agreement between Purchaser and Provider relating to the subject matter set forth herein. This addendum supersedes any and all prior oral discussions, promises, representations, and understandings between Purchaser and Provider relating to the subject matter of the addendum, excepting only the separate understanding and agreement between the parties in the 2006 Purchase of Service Contract. This addendum may not be modified or amended except pursuant to a written document signed by an authorized officer or representative of each party.